U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 04 April 2003

In the Matter of	:	
ARNOLD I. KEEN,	:	
Claimant	:	
	:	
	:	Case No. 2002-BLA-00282
v.		:
		:
BEATTRICE POCAHONTAS CO.		:
Employer	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS'	:	
COMPENSATION PROGRAMS	:	
Party-in-Interest		:

DECISION AND ORDER

AWARDING BENEFITS ON MODIFICATION

This case comes on a request for hearing filed by the Claimant, Arnold I. Keen[1], on March 6, 2002 pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§901 et seq. (the Act.). Claimant originally filed a claim for Black Lung benefits on July 5, 1979. This claim involves a request for modification filed by the Claimant on August 24, 2001.The claim was sent by the District Director to this Office on March 29, 2002 (Director's Exhibit, hereinafter "DX" 158).

At hearing in Abingdon, Virginia on November 19, 2002, the Claimant appeared and participated. The Claimant is represented by Joseph Wolfe, Esquire, Wolfe and Farmer, Norton, Virginia. The employer is represented by Douglas A. Smoot, Esquire, Jackson and Kelly, Charleston, West Virginia. The Solicitor did not appear at hearing and has not submitted a brief, although the Solicitor appeared in two (2) post hearing telephone conferences. One hundred fifty-nine (159) Director's Exhibits (hereinafter "DX"1 through DX 159), one (1) Claimant's Exhibit (hereinafter "CX" 1), and eleven (11) Employer's Exhibits ("EE" 1 to EE 11) were admitted into evidence at hearing. Former DX 109 was stricken from this record.[2] Following the hearing, the Claimant was granted the opportunity to submit a brief, and the Employer was given

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[1] Although some of the documents refer to the Claimant as I. Arnold Keen, when asked to state his name for the record, the Claimant stated his name is "Arnold Keen", Transcript (hereinafter "Tr":), page 12. The application lists the name as I. Arnold Keen, DX 1. The claim file was submitted to this office bearing the name, Arnold I. Keen (DX 158, DX 159).

[2] See Tr at 7 to 8.

time to brief or respond. Although the Claimant and the Director did not file a brief, Ashley M. Harman, Esquire and Mr. Smoot submitted a brief for the Employer, Beatrice Pocohantas Company.[3] In the telephone conference held March 26, 2003, the Request for Hearing dated March 26, 2002 was admitted into evidence as DX 160.

Although the Department of Labor initially awarded benefits in this claim (DX 16), Administrative Law Judge V. M. McElroy denied benefits on February 23, 1988 subsequent to a formal hearing (DX 36). At that time, Judge McElroy found that the Employer conceded on the issue of pneumoconiosis and he independently found that Mr. Keen has simple pneumoconiosis and was entitled to the benefit of the interim presumption under 20 CFR §727.203(a)(1). Id at 6. Judge McElroy issued a decision denying benefits based on his conclusion that Employer effectively rebutted the interim presumption of total disability pursuant to 20 C.F.R. § 727.203(b)(2) and (b)(3). The Claimant appealed the denial to the Benefits Review Board, but then withdrew the appeal (DX 37, 41, 42). Within one year of this initial denial, on September 14, 1988, the Claimant requested modification (DX 43). The Department of Labor denied the modification request (DX 57), and forwarded the file to the Office of Administrative Law Judges (OALJ) for a hearing. DX 65.

Administrative Law Judge Stuart A. Levin presided at a second hearing on January 12, 1993. DX 84. Judge Levin issued a Decision and Order Denying Benefits on August 3, 1993, finding the evidence insufficient to establish either a material change in condition or a mistake of fact. Judge Levin also found that the evidence was insufficient to establish the existence of complicated pneumoconiosis, or a totally disabling pulmonary impairment due to coal workers' pneumoconiosis. DX 88. The Claimant appealed the denial to the Benefits Review Board. DX 89, 91. On April 27, 1995, the Board affirmed the denial of benefits. DX 94.

By letter dated April 2, 1996, the Claimant requested a second modification, and submitted an additional report interpreting a chest X-ray dated February 11, 1996 as showing complicated pneumoconiosis. DX 95. Following review of a re-reading of the February, 1996 X-ray as negative for complicated pneumoconiosis (DX 100), the District Director, OWCP denied modification (DX 101) and forwarded the matter to the Office of Administrative Law Judges. DX 105.

In lieu of a formal hearing, the parties agreed to a decision on the record. On February 27, 1998, Judge Levin issued a Decision and Order Denying Benefits on Modification. DX 113. The Claimant filed a timely *pro se* appeal to the Benefits Review Board. DX 114. On April 15, 1999, the Benefits Review Board vacated the denial of benefits and remanded the case to Judge Levin with instructions to review all evidence of record de novo, and to provide adequate findings of fact and conclusions of law concerning his decision. DX 117.

On January 5, 2000, Judge Levin issued a Decision and Order on Remand again denying benefits and finding the Claimant failed to establish the existence of complicated pneumoconiosis, a change in condition, or a mistake of fact DX 120. He also found the Employer established

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[3] Beatrice Pocahontas Company, is a wholly-owned subsidiary of Island Creek and Island Creek is now a wholly-owned subsidiary of Consolidation Coal Company. Tr.9.

rebuttal of the interim presumption of total disability in accordance with § 727.203(b)(3). Id. The Claimant did not appeal this decision.

The Claimant requested modification for a third time on April 7, 2000, submitting an X-ray reading by Dr. Kathleen A. Deponte, dated March 15, 2000, wherein she interpreted it as positive for complicated pneumoconiosis. DX 121. The District Director issued an order to show cause why modification should not be granted on August 30, 2000. DX 124. Following additional evidentiary development by the parties, the District Director issued a Proposed Decision and Order Denying Request for Modification. DX 142. The Claimant requested a formal hearing and the District Director forwarded the claim to the OALJ. DX 144.

Administrative law judge Richard T. Stansell-Gamm issued a Notice of Hearing, but then received correspondence stating the Claimant had not intended to request a hearing, but had intended to file a new modification request. Accordingly, Judge Stansell-Gamm issued an order on July 19, 2001 remanding the claim to the District Director for further administrative action as appropriate. DX 150.

On June 9, 2001, the Claimant issued a letter to the District Director requesting withdrawal of his current claim so that he could file a new claim under the revised 2001 regulations. DX 147. The claims examiner responded to the request explaining that a withdrawal of the current claim may not be in the Claimant's best interest. The claims examiner gave various recommendations concerning an appropriate course of action, and required the Claimant's counsel specifically state why it would be in Mr. Keen's best interest to withdrawal the pending claim. Claimant's counsel reconsidered the withdrawal request, requested that the scheduled hearing be canceled, and stated that Mr. Keen would file an additional modification request to keep his pending claim alive under the 727 regulations. DX 149.

Mr. Keen filed his current modification request on August 24, 2001 submitting additional medical records including a CT scan report, a single X-ray reading, and a one-page report from Dr. Robinette. DX 151. The Department of Labor responded to the modification on September 7, 2001 granting 30 days submit additional evidence concerning the modification. DX 152. Both parties developed additional evidence. On March 4, 2002, the District Director issued a Proposed Decision and Order Denying the request for Modification. The Claimant requested a formal hearing on March 26, 2002. DX 160.

Burden of Proof

"Burden of proof," as used in the this setting and under the Administrative Procedure Act[4] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof". "Burden of proof" means burden of persuasion, not merely burden of production. 5

[4]33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

U.S.C.A. § 556(d)[5]. The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [Ondecko], 512 U.S. 267, 114 S.Ct. 2251 (1994).[6]

The Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. ***Gee v. W.G. Moore and Sons***, 9 B.L.R. 1-4 (1986)(*en banc)*; ***Baumgartner v. Director, OWCP***, 9 B.L.R. 1-65 (1986)(*en banc)*.

A Claimant has the general burden of establishing entitlement *and* the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[7] Therefore, the claimant cannot rely on the Director to gather evidence.[8] A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985). Evidence which is in equipoise is insufficient to sustain claimant's burden in this regard. ***Director, OWCP v. Greenwhich Colleries, et al.,*** 114 S. Ct. 2251 (1994), *aff'd sub nom.* ***Greenwhich Collieries v. Director, OWCP,*** 990 F.2d 730 (3rd Cir. 1993). Failure to establish any one of these elements will result in a denial of benefits. ***Hall v. Director, OWCP,*** 2 B.L.R. 1-998 (1980).

Nature and Scope of a Modification Proceeding

In evaluating a modification request based on an alleged change in conditions, an administrative law judge is required to undertake a *de novo* consideration of the issue by first independently assessing the newly submitted evidence to determine whether it is sufficient to establish the requisite change in conditions. If a change is established, the administrative law judge must then consider all of the evidence of record to determine whether the claimant has established entitlement to benefits on the merits of the claim. ***Kovac v. BNCR Mining Corp.***, 14 B.L.R. 1-156 (1990, *modified on reconsideration*, 16 B.L.R. 1-71 (1992).[9] *See also,* ***Nataloni v.***

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[5] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [*Sainz*], 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[6] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev.1981).

[7] ***Id***, *also see* ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

[8] ***Id***.

[9] In its decision on reconsideration, the Board modified its holding in *Kovac* by stating that new evidence is not a prerequisite to a modification based on an alleged mistake in a determination of fact; rather, "[m]istakes of fact may be corrected whether demonstrated by new evidence, cumulative

Director, OWCP, 17 B.L.R. 1-82 (1993) and ***Kingery v. Hunt Branch Coal Co.***, 19 B.L.R. 1-8 (1994). In ***Kingery***,the Board, citing its decisions in ***Kovac*** and ***Nataloni***, described the proper scope of the *de novo* review of a modification request as follows:

> [A]n administrative law judge is obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish at least one element of entitlement which defeated entitlement in the prior decision.

Id. At 11.

The Board has also held that the Administrative Law Judge should always review the record on modification to assess whether a mistake of fact has occurred. *Id.* In determining whether a mistake of fact has occurred, the Administrative Law Judge has broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted. ***Jessee v. Director, OWCP***, 5 F.3d 723 (4th Cir. 1993).

Issue

This decision is limited to whether the Claimant has established the existence of complicated pneumoconiosis. Although evidence of complicated pneumoconiosis was not established prior to April 15, 2002, as I find in favor of the Claimant on this issue, I need not discuss rebuttal evidence proffered by the Employer.

Although the Employer made a qualified objection to the Claimant's wife's dependency, the record shows that the Claimant is married to Ruth Keen, who he married on April 22, 1988. DX 84 at 50, Tr 13, and who is his dependant for augmentation under the Act.[10]

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X-ray and CT Evidence

The following is a summary:

X-RAYS

DATE OF X-RAY	***DATE OF INTERPRETATION***	***READING***	***EXH.***	***PHYSICIAN***
07/11/73		07/11/73	DE 11	Cunningham 1; p
02/18/77		02/18/77	DE 12	Evans 1; q
02/18/77		09/28/77	DE 13	McCluney 2/2; q
02/18/77		11/24/81	DE 22	Bassali 3/2; q/t
	06/08/77		DE 14	? 1/0; r
01/28/81		01/28/81	DE 19	Cunningham 1/1;q
01/28/81		11/15/85	DE 26	Evans 1/2; p/q; em

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evidence, or further reflection on the evidence initially submitted." *Id.* At 73.

[10] Mr. Smoot (for the Employer): Your Honor, we take the position that a certificate of marriage really ought to be of record before we actually stipulate to it. I've heard it him testify here today and I take his word for it, but I think if you were to award benefits the Department of Labor would require that he submit that at some point during the proceedings. TR, 17.

04/23/85	04/24/85	DE 26	Evans	Pneumoconiosis; pulmonary emphysema; possible neoplastic lesion
04/23/85	02/06/89	DE 69	Cole “B/BCR”	2/2; ax; di; pi
05/10/85	05/10/85	DE 26	Evans	Pneumoconiosis; pulmonary emphysema
05/10/85	11/15/85	DE 26	Evans	2/2; q/r; em
05/10/85	02/06/89	DE 69	Cole “B/BCR”	2/2; ax; di; pi
06/28/85	02/06/89	DE 69	Cole “B/BCR”	2/2; ax; di; pi
06/28/85	06/28/85	DE 26	Evans	Pneumoconiosis; pulmonary emphysema
06/28/85	11/15/85	DE 26	Evans	2/2; q/r; tb(?); em
10/29/86	05/07/87	DE 29	Modi	2/1; q/r
10/29/86	07/24/96	DE 99	Wheeler “B/BCR”	2/2; 0; ax; em; pi; tb; od; comments
10/29/86	07/09/97	DE 108	Kim “B/BCR”	2/2; q/t; ax; em; comments
10/29/86	07/31/97 ax; bu	DE 110	Fino “B”	1/1; r/q; Cat. O;
06/11/87	06/11/87	DE 31; 33	Poulos	2/2; q/r
06/11/87	03/28/89	DE 69	Scott “B/BCR”	2/2; ax
06/11/87	03/28/89	DE 69	Templeton “B/BCR”	2/2; ax
03/18/88	07/09/97	DE 108	Kim “B/BCR”	2/1; q/t; od; ax; em; tb; comments
03/18/88	07/31/97	DE 110	Fino “B”	1/1; r/q; ax; bu
08/18/88	08/18/88	DE 43	Mullens	Nodular interstitial lung disease consistent with silicosis
08/18/88	09/02/88	DE 43	Robinette “B”	2/1; q/r; Cat. A; ax; di; em

08/18/88	1	0/19/88	DE 44	Wiot “B/BCR”	UR
08/18/88		10/29/88	DE 44	Spitz “B/BCR”	UR
08/18/88		03/28/89	DE 69	Templeton “B/BCR”	2/2; ax
08/18/88		03/30/89	DE 69	Scott “B/BCR”	2/2; ax
08/18/88		10/17/89	DE 56	Pittman	1/2; Cat.A
08/18/88		07/09/97	DE 108	Kim “B/BCR”	1/1; q/q; od; em; tb; comments
08/18/88		07/31/97	DE 110	Fino “B”	1/1; r/q; ax; bu
12/06/88		04/07/89	DE 69	Dahhan “B”	1/1; ax
12/06/88		04/17/89	DE 69	Broudy “B”	2/1
06/22/89			DE 50	Sutherland	2/2
06/22/89		07/25/89	DE 54	Broudy “B”	1/1; r/q; od; comments
06/22/89		07/24/96	DE 99	Wheeler “B/BCR”	2/2; q/q; em; tb; od; comments
06/22/89		07/09/97	DE 108	Kim “B/BCR”	2/1; q/t; od; ax; em; tb; comments
06/22/89		07/31/97	DE 110	Fino “B”	1/1; r/q; ax; bu
02/26/90		02/27/90	DE 63	Stewart “B”	1/2; ax; bu; tb
02/26/90		03/16/90	DE 69	Broudy “B”	2/1; ax; fr
02/26/90		03/27/90	DE 64	Dahhan “B”	1/1; q/r; ax; em
02/26/90		07/09/97	DE 108	Kim “B/BCR”	2/1; q/q; od; ax; em; tb; comments
02/26/90		07/31/97	DE 110	Fino “B”	1/1; r/q; ax; bu
02/26/90 A	03/03/02	DE 157	Navani “B/BCR”	1/ 2; q/t; “O”; ax; bu; ef; em; comments	
02/26/90 B	03/03/02	DE 157	Navani “B/BCR”	1/ 2; q/t; “O”; bu; ef; em; comments	
02/26/90		08/09/02	EE 6	Scatarige “B/BCR”	1/0; q/r; od; tb(?); comments

02/26/90		09/24/02	EE 8	Repsher “B”	No evidence of coal workers’ pneumo coniosis; di hi; tb; commen ts
05/04/92		05/04/92	DE 68	Cappiello “B/BCR”	1/2; Cat. A; ax
05/04/92	05/12/92	DE 68	Aycoth “B/BCR”	2/3; Cat. A	
05/04/92		11/15/92	DE 77	Khouri “B/BCR”	2/2; r/q; ax; em
05/04/92		07/09/97	DE 108	Kim “B/BCR”	2/2; q/q; od; ax; em; tb; commen ts
05/04/92		07/31/97	DE 110	Fino “B” 1/1; r/q; ax; bu	
07/11/92		07/12/92	DE 72	Dahhan “B”	1/2; ax; tb?
07/11/92		09/09/92	DE 74	Wheeler “B/BCR”	2/1; q/q; ax; em; commen ts
07/11/92		09/09/92	DE 74	Scott “B/BCR”	2/1; q/r; ax; em; commen ts
07/11/92		10/06/92	DE 75	Fino “B” 1/1; r/r	
07/11/92		10/26/92	DE 76	Pendergrass “B/BCR”1/2; u/u; ax; em; fr; comments	
07/11/92		11/15/92	DE 77	Khouri “B/BCR”	2/2; r/q; ax; em
07/11/92		07/09/97	DE 108	Kim “B/BCR”	1/1; q/q; od; ax; em; tb; commen ts
07/11/92		07/31/97	DE 110	Fino “B” 1/1; r/q; ax; bu	
07/11/92		03/03/02	DE 157	Navani “B/BCR”	1/ 2; q/t; “O”; ax; ef; em; commen ts
07/11/92		08/02/02	EE 6	Scatarige “B/BCR”	1/0; q/r; od; tb(?);

				comments
07/11/92	09/24/02	EE 8	Repsher “B”	No evidence of coal workers’ pneumo coniosis; di; hi; tb; commen ts
02/14/96	02/27/96	DE 95	Alexander “B/BCR”	2/2; Cat. B; r/q; ax; em; bu; di; pi
02/14/96	07/24/96	DE 99	Wheeler “B/BCR”	2/2; q/q; em; tb; od; commen ts
02/14/96	09/15/96	DE 100	Francke “B/BCR”	1/1 0-coalesce nce but not a mass “yet”; pl. th.
02/14/96	01/27/97	DE 104	Dahhan	1/ 2; q/q; ax
02/14/96	07/09/97	DE 108	Kim “B/BCR”	2/2; q/q; od; em; tb; commen ts
02/14/96	07/31/97	DE 110	Fino “B”	1/1; r/q; ax; bu
02/14/96	02/18/01	DE 135	Navani “B/BCR”	1/1; r/t; bu; pi
02/17/97	12/27/00	DE 133	Dahhan “B”	0/1; q/q; em
02/17/97	01/31/01	DE 137	Wheeler “B/BCR”	0/1; q/q; em; tb; commen ts
02/17/97	02/01/01	DE 137	Scott “B/BCR”	No evidence of coal workers’ pneumo coniosis; tb; commen ts

02/17/97	02/13/01	DE 137	Kim “B/BCR”	No evidence of coal workers’ pneumo coniosis; od; tb; commen ts
02/17/97	03/03/02	DE 157	Navani “B/BCR”	1/ 2; q/t; “B”; a/x; bu; ef; em; pi; commen ts
02/17/97	08/09/02	EE 6	Scatarige “B/BCR”	1/0; r/r; od; ca(?); fr; tb(?); commen ts
02/17/97	09/24/02	EE 8	Repsher “B”	u/r
03/15/00	03/17/00	DE 121; 125	DePonte “B/BCR”	1/0; “B”; q/p
03/15/00	08/07/00	DE 123	Navani “B/BCR”	1/0; Cat. A; q/s; ax; di; em; tb; commen ts
03/15/00	09/26/00	DE 126	Wheeler “B/BCR”	1/0; q/q; od; ca; tb; commen ts
03/15/00	09/26/00	DE 126	Scott “B/BCR”	No evidence of coal workers’ pneumo coniosis; od; ca(?); commen ts
03/15/00	10/04/00	DE 126	Kim “B/BCR”	No evidence of coal workers’

				pneumo coniosis; od; ca; commen ts
03/15/00	10/23/00	DE 127	Dahhan “B”	1/2; q/q; ax; ca(?)
03/15/00	03/17/01	DE 138	Navani “B/BCR”	2/1; Cat. B; q/r; ax; bu; em
03/15/00	08/09/02	EE 6	Scatarige “B/BCR”	1/0; r/q; od; ca(?); tb(?); commen ts
03/15/00	09/24/02	EE 8	Repsher “B”	No evidence of coal workers’ pneumo coniosis; di; hi; tb; commen ts
06/05/00	06/06/00	DE 134	Forehand “B”	1/ 2; Cat. B; q/q; ca; di; tb
06/05/00	02/18/01	DE 136	Navani “B/BCR”	1/ 2; Cat. A; r/q; ax; di; pi; commen ts
06/05/00	07/13/01	DE 153	Scott “B/BCR”	No evidence of coal workers’ pneumo coniosis; ca; tb; commen ts
06/05/00	07/14/01	DE 153	Wheeler “B/BCR”	No evidence of coal workers’

				pneumoconiosis; od; ca(?); tb; comments
06/05/00	08/01/01	DE 153	Kim “B/BCR”	No evidence of coal workers’ pneumoconiosis; od; ca; tb; comments
06/05/00	12/21/01	EE 3	Dahhan “B”	2/1; q/q; ax; bu; ca; em; comments
09/25/00	10/06/00	DE 130	Robinette “B”	1/2; Cat. A; q/t; ax; di; em; od; comments
09/25/00	09/25/00	DE 130	Coburn	Changes consistent with coal workers’ pneumoconiosis with small rounded and small irregular densities diffusely throughout both lung fields and retraction of the hilar region with coalescence in upper lung zones
09/25/00	01/31/01	DE 137	Wheeler “B/BCR”	0/1; q/q; od; ca(?); em; tb; comments
09/25/00	02/01/01	DE 137	Scott “B/BCR”	No evidence

				of coal workers' pneumo coniosis; od; ca; tb; commen ts
09/25/00	02/13/01	DE 137	Kim "B/BCR"	No evidence of coal workers' pneumo coniosis; od; ca; tb; commen ts
09/25/00	03/03/02	DE 157	Navani "B/BCR"	1/ 2; "B"; q/t; ax; bu; ef; em; pi; commen ts
09/25/00	12/03/01	EE 3	Dahhan "B"	1/2; q/q; ax; em
09/25/00	08/09/02	EE 6	Scatarige "B/BCR"	1/0; r/q; od; commen ts
09/25/00	09/24/02	EE 8	Repsher "B"	u/r
12/04/00	12/04/00	DE 131	Dahhan "B"	1/2; q/q; ax; ca(?)
12/04/00	01/08/01	DE 132	Wheeler "B/BCR"	No evidence of coal workers' pneumo coniosis; od; ca(?); em; tb; commen ts
12/04/00	01/08/01	DE 132	Scott "B/BCR"	No evidence of coal workers' pneumo

				coniosis; ca(?); tb(?); comments
12/04/00	01/17/01	DE 133	Kim “B/BCR”	No evidence of coal workers’ pneumoconiosis; od; ca; tb; comments
12/04/00	03/17/01	DE 139	Navani “B/BCR”	2/2; Cat. B; q/r; ax; di; em; pi
12/04/00	08/09/02	EE 6	Scatarige “B/BCR”	1/0; q/r; od; ca(?); tb(?); comments
12/04/00	09/24/02	EE 8	Repsher “B”	No evidence of coal workers’ pneumoconiosis; di; hi; tb; comments
12/09/00	12/16/00	DE 130	Deponte “B/BCR”	1/1; Cat. B; q/p; ca; di; comments
12/09/00	02/07/01	DE 137	Wheeler “B/BCR”	No evidence of coal workers’ pneumoconiosis; od; em; comments

12/09/00	02/07/01	DE 137	Scott “B/BCR”	No evidence of coal workers’ pneumo coniosis; ca(?); em; tb(?); commen ts
12/09/00	02/17/01	DE 137	Kim “B/BCR”	No evidence of coal workers’ pneumo coniosis; od; ca; cn(?); em; tb; commen ts
12/09/00	03/17/01	DE 140	Navani “B/BCR”	2/1; q/r; “B”; ax; di; em
12/09/00	12/21/01	EE 3	Dahhan “B”	2/2; q/q; ax; bu; em; commen ts
12/09/00	08/09/02	EE 6	Scatarige “B/BCR”	1/0; r/q; od; commen ts
12/09/00	09/24/02	EE 8	Repsher “B”	u/r
03/13/01	12/08/01	EE 1	Wheeler “B/BCR”	No evidence of coal workers’ pneumo coniosis; od; ca(?); em; tb(?); commen ts
03/13/01	12/07/01	EE 1	Scott “B/BCR”	0/1; t/q; ca(?); tb(?);

				comments
03/13/01	03/03/02	DE 157	Navani “B/BCR”	1/2; q/t; “B”; ax; bu; ef; em
03/13/01	08/09/02	EE 6	Scatarige “B/BCR”	1/0; q/r; od; comments
03/13/01	09/24/02	EE 8	Repsher “B”	u/r
04/15/02	04/26/02	CX	DePonte “B/BCR”	1/1; q/q; Cat. B; ax; em
04/15/02	07/03/02	EE 4	Wheeler “B/BCR”	No evidence of coal workers’ pneumoconiosis; od; tb; comments
04/15/02	07/03/02	EE 4	Scott “B/BCR”	No evidence of coal workers’ pneumoconiosis; ca(?); tb; comments
04/15/02	07/03/02	EE 4	Scatarige “B/BCR”	No evidence of coal workers’ pneumoconiosis; od; ca(?); fr; tb(?); comments
04/15/02	08/09/02	EE 5	Dahhan “B”	0/1; q/r; “O”; ca; comments
04/15/02	09/19/02	EE 8	Repsher “B”	u/r

CT SCANS

DATE OF SCAN	***DATE OF READING***	***EXH.***	***MEDICAL PROVIDER***	***INTERPRETATION***
04/26/01CT	04/26/01	DE 151	Johnston Mem. Hosp.	Findings consistent with silicosis/coal workers' pneumoconiosis. Conglomerate mass in right perihilar region is felt to represent progressive massive fibrosis. Early consolidative changes in left perihilar region as well. Mediastinal and hilar adenopathy is probably due to granulomatous process.
04/26/01CT	12/13/01	EE 1	Wheeler "B/BCR"	No silicosis or coal workers' pneumoconiosis; minimal emphysema with subtle areas of decreased and distorted lung markings in both lungs
04/26/01CT	12/12/01	EE 1	Scott "B/BCR"	5 cm mass posterior right upper lung: cancer vs. granulomatous. Some blebs are present posterior to mass. Few small nodules so a very small component of silicosis/CWP cannot be excluded
04/26/01CT	03/03/02	DE 157	Navani "B/BCR"	1/ 2; q/t; "B"; ax; bu; ef; em; comments
04/26/01CT	08/13/02	EE 6	Scatarige "B/BCR"	4.0 x 5.5 cm smoothly-marginated opacity in posterior segment of RUL. Patent bronchi with air bronchogram and associated volume loss in RUL. Favor inflammatory disease such as tuberculosis or, less likely, an indolent neoplasm such as bronchoalveolar cell. Advise sputum examination and bronchoscopy for definite evaluation; reticulated opacities in apical posterior segment of LUL extend to the pleural surface where focal pleural calcification is noted. Findings suggest tuberculosis of unknown age. Few small, central nodules (1-3 mm) in posterior aspect of upper lobes; unknown significance, and compatible with granulomatous disease (TB, sarcoid). Cannot completely exclude due to pneumoconiosis; no evidence of mediastinal lymphadenopathy, interstitial fibrosis, or pleural effusion.
07/09/01CT	12/12/01	EE 1	Scott "B/BCR"	No change since exam of 4/26/01. 5 cm mass posterior right upper lung: cancer vs. granulomatous. Some blebs are present posterior to mass. Few small nodules so a very small component of silicosis/CWP cannot be excluded
07/09/01CT	12/13/01	EE 1	Wheeler "B/BCR"	No silicosis or coal workers' pneumoconiosis
07/09/01CT	03/03/02	DE 157	Navani "B/BCR"	1 /2; q/t; "B"; ax; bu; ef; em; comments
07/09/01CT	08/13/02	EE 6	Scatarige "B/BCR"	4.0 x 5.5 cm smoothly-marginated opacity in posterior segment of RUL, unchanged since 4/26/01. Patent bronchi with air bronchogram

and associated volume loss in RUL. Favor inflammatory disease such as tuberculosis. Advise sputum examination and bronchoscopy for definite evaluation. Reticulated opacities in apical posterior segment of LUL, unchanged, extend to the pleural surface where focal pleural calcification is noted. Findings suggest tuberculosis of unknown age. Few scattered central nodules in both upper lobes, less evident when compared to 4/26/01.

Evaluation of the Evidence

Mr. Keen initially filed his claim for federal black lung benefits on July 5, 1979, and has continually requested modification of Judge McElroy's and Judge Levin's denial decisions, making the claim subject to the Part 727 Regulations. Because the claim at issue was filed after January 1, 1974 and before March 31, 1980, and the miner had more than 10 years of coal mine employment, the regulations at 20 CFR Part 727 apply. *See* 20 CFR § 727.1 (2000)[11]; 20 CFR § 718.2 (2002); ***Pauley v. Bethenergy Mines, Inc.***, 501 U.S. 680 (1991). Disability benefits are payable to miners totally disabled by pneumoconiosis arising out of coal mine employment. 30 U.S.C. §§ 902(b) and 921(a). In part pertinent 20 CFR § 727.203 sets forth an interim presumption.

> (a) Establishing interim presumption. A miner who engaged in coal mine employment for at least 10 years will be presumed to be totally disabled due to pneumoconiosis, or to have been totally disabled due to pneumoconiosis at the time of death, or death will be presumed to be due to pneumoconiosis, arising out of that employment, if one of the following medical requirements is met:
>
> > (1) A chest roentgenogram (X-ray), biopsy, or autopsy establishes the existence of pneumoconiosis (see §410.428 of this title);

In the initial hearing in this matter before Judge McElroy in 1988, the parties stipulated to the existence of simple coal workers' pneumoconiosis. DX 36 at 3; also see Conclusion at 6. I have scrutinized the entire medical record, and find that the Claimant has "invoked" a rebuttable presumption as of the date of his most recent request for modification. 20 CFR §727.203(a)(1). Id.[12]

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[11]Part 727 last appeared in the 2000 edition of the Code of Federal Regulations. The Department of Labor decided not to republish Part 727 in later editions because relatively few claims are still subject to those regulations. 65 Fed. Reg. 80029, 80107 (2000).

[12] A central feature of the Part 727 regulations are the interim presumptions at 20 C.F.R. § 727.203(a), which provide that a miner, with at least ten years of coal mine employment, is entitled to the following rebuttable presumptions of total disability or death arising out of coal mine employment:

If a claim falls under Part 727 or § 410.490, and the claimant has established invocation of an interim presumption by a preponderance of the evidence, then the burden shifts to the party opposing entitlement to establish rebuttal by a preponderance of the evidence. The record shows that (as of the Decision and Order dated January 5, 2000) the Employer had proved rebuttal.

Subsequent to Judge Levin's 2000 Decision and Order, new evidence submitted by the Claimant includes an X-ray performed March 15, 2000, which was read by Dr. Shiv Ninani and Dr. . Deponte as indicative of complicated pneumoconiosis (DE 121, DE 125, DE 138); a June 5, 2000 X-ray was read as positive for complicated pneumoconiosis by Dr. Navani and by Dr. Randy Forehand (DE 136, DE 134); an X-ray report of from September 25, 2000, read by Dr. Emory Robinette, Dr. Ernest Coburn and Dr. Navani as showing complicated pneumoconiosis (DE 130, DE 157) an X-ray taken December 4, 2000 read by Dr. Navani as positive for complicated pneumoconiosis (DE 139); and an X-ray taken December 9, 2000, was read by Dr. Navani as positive for complicated pneumoconiosis (DE 140). With the request for modification, the Claimant submitted a report of a portable chest x-ray dated March 13, 2001, reviewed by Dr. Richard Mullens, a CT scan report dated April 26. 2001, and a one page report from Dr. Emory H. Robinette. DX 151. After the Claim was reviewed by the District Director, the Claimant submitted an X-ray reading by Dr. Deponte dated April 15, 2002. CX 1.

Complicated Pneumoconiosis.

30 USC §921 (c) states in part pertinent:

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(1) that the miner is totally disabled due to pneumoconiosis;

(2) that the miner was totally disabled due to pneumoconiosis at the time of death; and

(3) that the miner's death was due to pneumoconiosis upon invocation.

The presumptions are "invoked" if any one of the following five evidential requirements is satisfied:

(1) chest X-ray evidence establishes the existence of pneumoconiosis;

(2) ventilatory studies establish the presence of a chronic respiratory or pulmonary disease;

(3) blood gas studies demonstrate the presence of an impairment in the transfer of oxygen;

(4) well-reasoned, well- documented medical reports support a finding of a totally disabling respiratory impairment; or

(5) lay testimony as to the miner's condition in the case of a deceased miner.

20 C.F.R. §§ 727.203(a)(1)-(5).

The definition of "pneumoconiosis" is set forth at § 727.202, which provides the following:

[A] chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis anthro-silicosis, massive pulmonary fibrosis, progressive massive fibrosis silicosis, or silicotuberculosis arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 727.202.

(3) If a miner is suffering or suffered from a chronic dust disease of the lung which (A) when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization, (B) when diagnosed by biopsy or autopsy, yields massive lesions in the lung, or (C) when diagnosis is made by other means, would be a condition which could reasonably be expected to yield results described in clause (A) or (B) if diagnosis had been made in the manner prescribed in clause (A) or (B), then there shall be an irrebuttable presumption that he is totally disabled due to pneumoconiosis or that his death was due to pneumoconiosis, or that at the time of his death he was totally disabled by pneumoconiosis.as the case may be.

The Department of Labor uses a standard X-ray form to evaluate pneumoconiosis. 2C of the standard X-ray report contains the letters O, A, B, and C. If the physician checks A, B, or C, the x-ray yields evidence that the miner suffers from complicated pneumoconiosis. A mark of "O" indicates that complicated pneumoconiosis is not present. Complicated pneumoconiosis is an extremely advanced stage of the lung disease, and a miner who suffers from complicated pneumoconiosis will be entitled to certain presumptions regarding total disability arising from the disease under some of the applicable regulatory schemes.

Recent X-rays

Because the interim presumption has been established, based on X-ray evidence, I will first discuss the new X-ray evidence. Dr. Deponte, a board-certified radiologist and B-reader, interpreted the April 15, 2002 X-ray, the most recent, as showing a 1/1 profusion of "q" shaped opacities in the upper four lung zones, as well as a "B" large opacity. CX 1. She is not the first time she has done so; Dr. Deponte read the March 15, 2000 and December 9, 2000 X-rays as showing complicated pneumoconiosis. DE 121, DE 125, DE 130.

The Claimant requested modification based on a similar allegation in 1996. See DE 120.[13] Similar findings were made in X-rays taken in 1988 and 1992 and 1997. See DE 43, DE 50, DE 56, DE 157 and DE 68.

Dr. Paul S. Wheeler and Dr. John C. Scatarige, both board certified radiologists and “B” readers, determined that the March 15, 200 X-ray showed that there was simple, but not complicated, pneumoconiosis. DE 126, EE 6. Dr. A. Dahhan, a “B” reader, made a similar finding. DE 127. William W. Scott, Jr. and Dr. Young Kim, board-certified radiologists and

[13] Judge Levin properly discounted Dr. Alexander s interpretation of the February 1996 X-ray as unsupported by the other five physicians who rendered a reading of that particular x-ray. There are other physicians in the record who diagnosed Claimant with complicated pneumoconiosis, but their conclusions were not based on the February 1996 X-ray. Instead, their conclusions are based on readings of prior x-rays, and their conclusions were also opposed by a majority of physicians interpreting the same films. Thus, no other Physician on record aside from Dr. Alexander read the February 1996 film as positive for complicated pneumoconiosis, and the majority of all prior x-ray films were read as negative for complicated pneumoconiosis. See Decision and Order dated January 5, 2000.

B-readers, interpreted the X-ray as showing no evidence of coal workers' pneumoconiosis. DE 126. Dr. Lawrence Repsher, also a "B:" reader agreed with Drs. Scott and Kim. EE 8.

Drs. Wheeler, Scott, and Kim read the June 5, 2000, the September 25, December 4, and December 9 X-rays as negative. DE 153, DE 137, DE 132, DE 133, DE 137 . Dr's Dahhan and Scatarige read the September 25 , December 4 and December 9 X-rays as positive for simple, but not complicated pneumoconiosis. EE 3, EE 6. Dr. Repsher found no evidence on the December 4 X-ray, and the December 9 X-ray to be unreadable. EE 8.

The Claimant also submitted an X-ray reading of a portable film taken following a bronchoscopy procedure dated March 13, 2001 interpreted by Dr. Richard Mullens. DX 151. He noted a nodular interstitial pattern in the mid and upper lung zones consistent with coal workers' pneumoconiosis/silicosis. He observed an ovoid 4 cm mass in the right supra hilar region, but otherwise noted clear lungs. Dr. Mullens opined the mass represented a neoplasm, rather than a conglomerate mass associated with interstitial lung disease. DX 151.

Dr. Wheeler interpreted the March 13, 2001 chest x-ray as a Quality 3 film finding it dark, portable, and showing scapulae on lungs. Dr. Wheeler gave a detailed report concerning his interpretation of this x-ray:

> Oval 5 cm wide and 4 cm high mass inferomedial portion RUL or superior segment RLL involving elevated right upper hilum compatible with inflammatory disease or cancer. Get CT scan followed by a bronchoscopy and biopsy. Ill-defined infiltrate or fibrosis in lateral left mid and upper lung involving pleura with possible few nodules compatible with pneumonia or granulomatous disease more likely than metatases. Well-inflated lungs compatible with deep breath or emphysema/check PFT's. Possible few tiny calcified granulomata and lower lungs from healed histoplasmosis. Possible focal blastic and lytic lesions in lateral portion clavicles/check for myeloma and prostate cancer. Minimal arteriosclerosis and tortuosity aorta and minimal scoliosis and degenerative arthritis t-spine. ECG leads... no silicosis or cwp but ILO classification was not intended for evaluation of a AP portable.

EE 1.

Similarly, Dr. Scott found the March 2001 portable film overexposed, and showing a 5 centimeter mass in the right upper lung representing cancer or granulomatous disease. Dr. Scott observed peripheral predominately linear infiltrates and/or fibrosis in the right and left upper lungs. Dr. Scott attributed these findings to tuberculosis or to other unknown activity. EE 1.

Dr. Scatarige also interpreted the March 13, 2001 chest x-ray, concurring with Drs. Wheeler and Scott that this film was overexposed with the scapula showing over the lungs. Dr. Scatarige made the following observations:

> 1. Ovoid mass in RUL with volume loss and scattered peripheral infiltrates/fibrosis LUL-favor TBC, chronic pneumonia.
>
> 2. Few scattered nodules in both upper lobes - central and peripheral - cannot R/O due to pneumoconiosis.
>
> 3. Osteoblastic bone metastasis - prostate cancer.

EE 6.

Dr. Shiv Navani, interpreted the March 13, 2001 portable chest X-ray as showing "B" large opacities. Dr. Navani also observed a 1/2 profusion of "q" and "p" shaped opacities in all six lung zones on the X-ray. DX 157.

The Employer argues that under the regulations, portable films are not to be used for classification under the ILO system. The regulations require:

> A chest roentgenogram shall be of suitable quality for proper classification of pneumoconiosis and shall conform to the standards for administration and interpretation of chest x-rays as described in Appendix A.

20 C.F.R. § 718.102(a). Among other required standards, Appendix A provides, "Every chest roentgenogram shall be a single postero-anterior projection..." Appendix A (1) to Part 718. Portable films do not meet this standard. ILO classifications of portable films are not be used to establish the presence of coal workers' pneumoconiosis.

I am also advised that the hospital physician, Dr. Mullens, did not indicate the presence of complicated coal workers' pneumoconiosis in his interpretation. DX 151.

Dr. Wheeler, Scott and Scatarige interpreted the April 15, 2002 X-ray as showing no evidence of coal workers' pneumoconiosis, but showing signs of obstructive lung disease, tuberculosis, and possibly cancer. See DX 153 and EE 4. Dr. A. Dahhan, interpreted the same x-ray as showing only a 0/1 profusion of "q" and "r" opacities in the upper right lung zone and no large opacities. Dr. Dahhan also noted the possible existence of cancer in the right upper lung zone. EE 5. Dr. Lawrence Repsher, also a"B" reader, found that the film quality was too poor to read the X-ray. EE 8.

Box 2B(c) of the standard X-ray form indicates the quantity of opacities in the lung and, therefore, the presence or absence of pneumoconiosis. The more opacities noted in the lung, the more advanced the disease. The categories are:

0 = small opacities absent or less profuse than in category 1.

1 = small opacities definitely present but few in number.

2 = small opacities numerous but normal lung markings still visible.

3 = small opacities very numerous and normal lung markings are usually partly or totally obscured.

If no categories are chosen, then the X-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis. Likewise, an X-ray which is interpreted as Category 0 (--/0, 0/0, 0/1) demonstrates, at most, only a negligible presence of the disease and will not support a finding of pneumoconiosis under the Act or regulations.

If the physician determines that the study is Category 1 (1/0, 1/1, 1/2), Category 2 (2/1, 2/2, 2/3), or Category 3 (3/2, 3/3, 3/+), then there is a definite presence of opacities in the lung and the x-ray report may be used as evidence of the existence of pneumoconiosis. An interpretation of 1/0 is the minimum reading under the regulations which will support a finding of pneumoconiosis. This reading (1/0) indicates that the physician has determined that the x-ray is Category 1, but he or she seriously considered Category 0. As another example, a reading of 2/2 indicates that the physician determined that the x-ray was Category 2 and Category 2 was the only other category seriously considered by the physician.

Therefore, as he determined that the X-ray disclosed 0,1, Dr. Dahhan also failed to diagnose even simple pneumoconiosis in reading the April 2002 X-ray.

CT Scans of April 26 and July 11, 2001

The Claimant also submitted readings of a CT scan dated April 26, 2001 in support of his modification claim. The radiology report from Johnston Memorial Hospital of this CT scan described the possible presence of progressive massive fibrosis in the right perihilar region. The reviewer noted:

> Findings consistent with silicosis/cwp. The conglomerate mass in the right perihilar region is felt to represent progressive massive fibrosis. There are early consolidative changes in the left perihilar region as well. The mediastinal and hilar adenopathy is probably due to the granulomatous process.

DX 151. However, the report does not clearly state the name of the physician making the interpretations. In order to invoke the interim presumption, an X-ray report must identify the reader.

Failure to identify the reader requires a remand where the administrative law judge relied on the x-ray over the objections of the aggrieved party at the hearing. ***Stanley v. Director, OWCP***, 7 BLR 1-386 (1984). The Sixth Circuit has held that if the reader is not identified, an x-ray reading has no evidentiary value. ***Director, OWCP v. Congleton***, 743 F.2d 428, 7 BLR 2-12 (6th Cir. 1984).

Although the report appears to be signed or initialed at the top by Dr. Emory H. Robinette, it is unclear whether Dr. Robinette or another physician made the interpretation, making it impossible to determine the credentials of the physician and the reliability of the report. As such, the report must be given very little weight concerning the existence of complicated coal workers' pneumoconiosis or progressive massive fibrosis in the Claimant.

Dr. Wheeler interpreted the Claimant's April 26, 2001 CT scan as showing:

> ...6x4 centimeter mass mainly in superior segment right lower lung but involving right hilum and upper oblique fissure in posterior edge of RUL compatible with inflammatory disease or cancer with no obvious calcification. Tiny linear scar or lymphatic spread extending from mass to focal posterior lateral pleural fibrosis or to tiny pleural mass (scan 21-24). Needs diagnosis by sputum or biopsy.
>
> Probably focal arteriosclerosis proximal left coronary artery but IV contrast makes this uncertain. Check for angina pectoris.
>
> Small linear and irregular fibrosis or possible infiltrate in posterolateral LUL involving pleura compatible with TB unknown activity probably healed.
>
> Minimal emphysema with subtle areas of decreased and distorted lung markings in both lungs. 7 mm calcified granuloma in inferior medial portion left CPA (scan 52) and possible tiny calcified granuloma and focal pleural fibrosis posterolateral pleural LUL (scan 15) compatible with healed histoplasmosis. Minimal arteriosclerosis aorta and degenerative arthritis T- spine.
>
> Minimal obesity. No silicosis or cwp. Small right renal cyst.

EE 1.

Similarly, Dr. Scott found a 5 centimeter mass posterior right upper lung representing cancer or granulomatous disease on the Claimant's April 26, 2001 CT scan. EE 1. Dr. Scott noted some blebs were present posterior to the mass. Dr. Scott also observed predominately linear fibrosis posterior upper lung extending to the pleura with associated pleural thickening probably due to healed tuberculosis. Dr. Scott noted the presence of a few small nodules so a very small component of silicosis/cwp could not be excluded. Dr. Scott also observed a 2 centimeter cyst on Mr. Keen's right kidney. Id.

Dr. Scatarige reviewed the April 26, 2001 CT scan as well. Dr. Scatarige observed a 4.0 x 5.5 cm smoothly-marginated opacity in the posterior segment of the right upper lung. Dr. Scatarige attributed the opacity to an inflammatory disease such as tuberculosis, or less likely, to an indolent neoplasm such as a bronchoalveolar cell. Dr. Scatarige advised a sputum examination and a bronchoscopy for a more definitive evaluation. Dr. Scatarige noted the presence of a few, small central nodules, 1-3 mm, in the posterior aspect of the upper lobes to which he attributed an unknown significance and which were compatible with a granulomatous disease such as tuberculosis or sarcoidosis. Dr. Scatarige could not completely exclude the possibility these small nodules were due to pneumoconiosis. Dr. Scatarige found no evidence of mediastinal lymphadenopathy, interstitial fibrosis, or pleural effusion. He also noted the presence of many bilateral osteoblastic lesions in the ribs and spine due to prostate cancer metastases, a small hiatal hernia, and a 2 cm cyst in the medial upper pole of the right kidney. EE 6.

Dr.Navani read a "B"sized opacity on the April 26, 2001 CT scan. Dr. Navani also observed a 1/2 profusion of "q" and "t" shaped opacities in all lung zones on the CT scan. Dr. Navani did not describe the specific location or the dimensions of the opacity in his report.

Interpretations of a follow-up CT scan dated July 9, 2001 are also of record. Dr. Scott interpreted this CT scan as showing no change since the CT scan of 26 April 2001. EE 1. Drs. Wheeler and Scatarige independently made the same observations, noting no change from the CT scan of 26 April 2001. EE 1, EE 6.

Other Evidence Relating to the Period
January 5, 2000 to April 15, 2002

The following other evidence is contained in this record:

11/15/00 Sherman DE 129

Professor of Medicine Drexel University School of Medicine's Pulmonary Division

1. Simple coal workers' pneumoconiosis.
2. Radiographic findings of large opacities reported may be due to metastatic lung disease, possibly from prostate cancer.
3. No evidence of any pulmonary impairment on any pulmonary function test submitted.
4. Recommend chest CT scan.

11/17/00 Robinette DE 130

Office visit:

1. Complicated coal workers' pneumoconiosis with apparent progressive massive fibrosis.
2. Prostatic carcinoma.
3. History of hypertensive cardiovascular disease.
4. Mild hyperglycemia.

5. Totally disabled from working as an underground coal miner based on his pulmonary disease alone.
6. Condition is chronic and irreversible.

12/04/00 12/06/00 Dahhan DE 131
Board Certified in Internal Medicine and Pulmonary Diseases.
NIOSH-Certified "B" Reader.
1. Radiological findings of simple coal workers' pneumoconiosis.
2. No findings to indicate the presence of complicated coal workers' pneumoconiosis.
3. From a respiratory standpoint has no objective findings to indicate any functional pulmonary disability.
4. From a respiratory standpoint retains the physiological capacity to continue his previous coal mining work or job of comparable physical demand.
5. Has essential hypertension and coronary artery disease which are conditions of the general public at large and are not caused by, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

03/13/01 Johnston Memorial Hospital DE 151
Bronchoscopy:
1. Nodular interstitial lung disease consistent with coal workers' pneumoconiosis/silicosis.
2. 4 cm RUL mass. This may represent a neoplasm. It is less likely that this represents a conglomerate mass associated with interstitial lung disease.

05/09/01 Robinette DE 151
1. Evidence of complicated coal workers' pneumoconiosis occurring as a consequence of his prior coal mining exposure.
2. No evidence of active fungal infection at this time and no evidence of tuberculosis or malignancy.

07/17/01 Broudy DE 155
01/10/02 Broudy Addendum
Board Certified in Internal Medicine and Subspecialty Pulmonary Medicine.
NIOSH Certified "B" Reader.
1. Simple coal workers' pneumoconiosis, but not complicated disease.
2. No evidence of significant pulmonary or respiratory impairment.
3. No evidence of impairment which could be attributed to pneumoconiosis.
4. Totally and permanently disabled from a respiratory standpoint.
5. Unlikely that he would be able to return to his regular coal mining work or work requiring similar effort considering his age and prostate cancer.
6. His disability or impairment is not caused in whole or in part by pneumoconiosis.
7. Those who did diagnose complicated pneumoconiosis confused the findings of granulomatous disease with complicated pneumoconiosis.

07/20/01 Dahhan DE 154
Board Certified in Internal Medicine and Pulmonary Diseases.
NIOSH-Certified "B" Reader.
1. Radiological evidence of simple coal workers' pneumoconiosis.
2. No evidence of complicated coal workers' pneumoconiosis.
3. No objective findings to indicate any pulmonary impairment and/or disability as demonstrated by the normal pulmonary function studies, arterial blood gases, spirometry, lung volumes and

diffusion capacity on multiple occasions including the most recent one from Dr. Robinette's office.

4. From a functional respiratory standpoint has no evidence of total or permanent pulmonary disability since he has no evidence of respiratory impairment in his functional pulmonary assessment.
5. Has cancer of the prostate with possible bony metastasis, a condition of the general public at large and is not caused by, related to, contributed to or aggravated by the inhalation of coal dust or workers' pneumoconiosis.

07/26/01 Tuteur EE 2

Board Certified in Internal Medicine and Pulmonary Diseases.

1. Evidence of simple coal workers' pneumoconiosis based on combination of history of exposure and chest radiographic findings.
2. Does not have pulmonary or respiratory impairment.
3. The abnormalities of chest radiograph that lead to the diagnosis of simple coal workers' pneumoconiosis are not responsible for any measurable impairment of pulmonary function.
4. Totally and permanently disabled to such an extent that he is unable to do his regular coal mining work or work requiring similar effort.
5. His disability is not caused in whole or in part by his pneumoconiosis.
6. Does not have impairment of pulmonary function.
7. His disability is a result of profound persistent and prolonged uncontrolled hypertension with resultant cardiac changes now with superimposed metastatic carcinoma of the prostate. None of these conditions are related to or aggravated by or caused by the inhalation of coal mine dust or the development of coal workers' pneumoconiosis.

08/04/01 Spagnolo DE 154

Board Certified in Internal Medicine and Critical Care Medicine and subspecialty Pulmonary Diseases.

1. Does not have simple or complicated coal workers' pneumoconiosis.
2. Does not have a pulmonary/respiratory impairment attributable to a pneumoconiosis or related to his prior coal mine employment.
3. Does not have consistent physical findings, or laboratory evidence of any chronic disease of the lung arising from his coal mine employment.
4. None of his symptoms, complaints, or medical conditions is related to his coal dust exposure or coal mine employment.
5. Even if it were later determined that he had pneumoconiosis, such a determination would not change my opinions.

12/07/01 Naeye EE 2

Board Certified in Pathology; Anatomic and Clinical.

1. Does not have tissue, radiologic, pulmonary function or arterial blood gas evidences of coal workers' pneumoconiosis.
2. No evidence of any abnormality in pulmonary function and arterial blood gas analyses at 81 years of age.
3. Does not suffer from any pulmonary or respiratory impairment.
4. Not totally disabled from any pulmonary disorder.
5. Coal workers' pneumoconiosis and occupational exposures to coal mine dust have not contributed to any pulmonary or respiratory impairments.

12/17/01 Tuteur Supplemental EE 2

Board Certified in Internal Medicine and Pulmonary Diseases.

1. Does not have complicated coal workers' pneumoconiosis.

09/12/02 Caffrey EE 7

Board Certified in Anatomical and Clinical Pathology.

1. The lung tissue at biopsy does not show pathologic evidence of coal workers' pneumoconiosis. Radiographic evidence supports a diagnosis of simple coal workers' pneumoconiosis.
2. Does not suffer from pulmonary or respiratory impairment based on normal ventilatory studies and arterial blood gas studies performed multiple times and as late as December 2000, 23 years after he retired from the coal mining industry.
3. No evidence of pulmonary or respiratory disability is evident in the medial records I reviewed.
4. Simple coal workers' pneumoconiosis present did not cause him pulmonary disability and certainly did not play any role in his other significant medical diseases, namely carcinoma of the prostate and hypertensive cardiovascular disease.
5. Would have developed his prostatic carcinoma and hypertensive cardiovascular diseases even if he had never worked in the coal mining industry.

09/24/02 Repsher EE 8

Board Certified in Internal Medicine, Subspecialty in Pulmonary Diseases and Critical Care.
NIOSH-Certified "B" Reader.

1. Not sufficient evidence to justify a clear cut diagnosis of coal workers' pneumoconiosis.
2. Never has and continues not to have any pulmonary or respiratory impairment.
3. Most likely totally and permanently disabled so that he would be unable to do his regular coal mine work or work requiring similar effort.
4. His impairment and disability are unrelated to his coal mine job or to any coal workers' pneumoconiosis.
5. His impairment and disability are related to his advanced age, widely metastatic cancer, and his multifactorial heart disease.
6. Even if he were demonstrated to have histologic evidence of coal workers' pneumoconiosis, my opinion would not change, since the amount of pneumoconiosis would be so small that it would not affect his lung function to any individually measurable degree.

10/04/02 Broudy Supplemental EE 9

Board Certified in Internal Medicine and Subspecialty Pulmonary Medicine.
NIOSH Certified "B" Reader.

1. Evidence of simple pneumoconiosis but no evidence of complicated pneumoconiosis or progressive massive fibrosis.
2. No pulmonary or respiratory impairment due to any cause.
3. Retains the respiratory capacity to perform the work of an underground coal miner.

10/08/02 Dahhan Supplemental EE 9

Board Certified in Internal Medicine and Pulmonary Diseases.
NIOSH-Certified "B" Reader.

1. Sufficient objective findings to justify the diagnosis of simple coal workers' pneumoconiosis.
2. No objective findings to indicate complicated coal workers' pneumoconiosis or progressive massive fibrosis.
3. From a functional respiratory standpoint has no evidence of total or permanent pulmonary disability.

4. From a respiratory standpoint retains the physiological capacity to continue his previous coal mining work or job of comparable physical demand.
5. Cancer of the prostate with widespread metastasis as well as hypertension and hypertensive cardiovascular disease, which are all conditions of the general public at large and is not caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

10/07/02 Tuteur Supplemental EE 10

Board Certified in Internal Medicine and Pulmonary Diseases.

1. Very mild simple coal workers' pneumoconiosis.
2. Does not have significant impairment of pulmonary function.
3. No pulmonary impairment can be or should be appropriately attributed to pneumoconiosis or any other coal mine dust-induced disease process.
4. Totally and permanently disabled to such an extent that he is unable to perform his regular coal mining work or work requiring similar effort because of his age, his poorly controlled hypertension, his metastatic malignancy.

10/23/02 Spagnolo Supplemental EE 11

Board Certified in Internal Medicine and Critical Care Medicine and subspecialty Pulmonary Diseases.

1. None of the newly received supplemental information provides any objective evidence for me to change my earlier opinion.
2. Does not have consistent physical findings or laboratory evidence of any chronic disease of the lung arising from his coal mine employment.
3. His lung function has remained stable over many years.
4. No evidence of a restrictive or obstructive lung impairment and has normal gas exchange at rest and during exercise.
5. Does not have a chronic pulmonary/respiratory impairment attributable to pneumoconiosis or related to his prior coal mine employment.
6. Even if it were determined at a later time that he had pneumoconiosis, my opinion with regard to his current respiratory complaints would remain unchanged.

For the period leading to the 2002 X-ray, after a review of all of the evidence, I accept that the Claimant did not prove that complicated pneumoconiosis was proven. As I have stated on several occasions, the record shows that the Claimant has established the benefit of the interim presumption at 20 CFR §727.203(a)(1). The bronchoscopy evidence goes to an attempt to prove that either the Claimant has complicated pneumoconiosis as evidence of biopsy under (a)(1) or that there is a plausible rationale to determine it under (a)(4). I also have evaluated the CT scans, and they also may be used under 20 CFR § 727.203(a)(4). A more thorough discussion of them is set forth below. They were reviewed with respect to the timeline discussed here. Although the hospital record and Dr.Robinette's opinion are proffered to show that the condition is complicated pneumoconiosis, using laboratory testing and the bronchoscopy, the reports from several of the Employer's experts must be credited on this point.

For example, Dr. Caffrey, board certified in pathology, determined that the lung tissue at biopsy does not show pathologic evidence of coal workers' pneumoconiosis. However, he noted that radiographic evidence supports a diagnosis of simple coal workers' pneumoconiosis. EE 7.

I also credit in part the opinion of Dr. Broudy, who is Board Certified in Internal Medicine with a Subspecialty in Pulmonary Medicine, and who is a "B" Reader. He also found simple coal workers' pneumoconiosis, but not complicated disease. Although he determined that Mr. Keen is totally and permanently disabled from a respiratory standpoint, and that it is unlikely that he would be able to return to his regular coal mining work or work requiring similar effort considering his age and prostate cancer, he determined that any disability or impairment is not caused in whole or in part by pneumoconiosis. Dr. Broudy had the opportunity to review all of the records. He notes Dr. Deponte's evaluation of the April 15, 2002 X-ray, but finds simple pneumoconiosis. EE 9.

I accord some weight to the opinion of Dr. Dahhan, DE 154, EE 9, limited to the time line in question. He found radiological evidence of simple coal workers' pneumoconiosis, but no evidence of complicated coal workers' pneumoconiosis, because he determined that from a functional respiratory standpoint Mr. Keen has no evidence of total or permanent pulmonary disability since he has no evidence of respiratory impairment in his functional pulmonary assessment. He noted that the Claimant has cancer of the prostate with possible bony metastasis, a condition of the general public at large that is not caused by, related to, contributed to or aggravated by the inhalation of coal dust or workers' pneumoconiosis.

I accord some weight to the opinions of Dr. Tuteur, board certified in internal medicine and pulmonary diseases. He found simple coal workers' pneumoconiosis, but determined that Mr. Keen is totally and permanently disabled to such an extent that he is unable to perform his regular coal mining work or work requiring similar effort because of his age, his poorly controlled hypertension, and metastatic malignancy. EE 10, EE 2. However, Dr. Tuteur relied on the opinions of Dr. Wheeler and Scott when rendering his opinion about the April 15, 2002 X-ray, and I discount this aspect of his opinion, for reasons that are more fully explained below. EE 10.

I discount the opinions of Drs.Repsher, Naeye, and Spagnolo, because they fail to find even simple pneumoconiosis in this record. EE 8, EE 2, DE 11, DE 154. Dr. Spagnolo also relied on the expertise of Dr. Wheeler and Scott when evaluating the X-ray evidence. See his report dated October 23, 2002, EE 11. I note that the X-ray of April 15, 2002 was available to him.

Discussion Re: §727 203(a)(1) and Complicated Pneumoconiosis

Although the evidence shows that there had been no mistake of fact or law and no change of condition prior to the taking of the most recent X-ray by Dr. Deponte, subsequently, there has been a change in condition in this case, and as of April 15, 2002, Mr. Keen has established proof of complicated pneumoconiosis.

The April 15, 2002 X-ray (CX 1) was taken more than a year after the March 13, 2001 X-ray, and more than nine months after the followup CT scan was taken. Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. ***Clark v. Karst-Robbins Coal Co***., 12 B.L.R. 1-149 (1989)(en banc); ***Casella v. Kaiser Steel Corp***., 9 B.L.R. 1-131 (1986). This rule should not be mechanistically applied, however, in situations where the evidence would tend to demonstrate an "improvement" in the miner's condition. In ***Lane Hollow Coal Co. v. Director, OWCP*** [Lockhart], 137 F.3d 799 (4th Cir. 1998), the Fourth Circuit upheld an award of benefits under

20 C.F.R. Part 727. Initially, the court noted that pneumoconiosis is "progressive and irreversible" such that it is proper to accord greater weight to later positive X-ray studies over earlier negative studies. It further stated that, generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition.[14]

I note that Dr. Deponte and Drs. Wheeler, Scott and Scatarige are equally qualified.[15]Dr. Deponte is board certified in Radiology, whereas Dr. Dahhan and Dr. Repsher are both board certified in internal medicine and pulmonology, but not in radiology. See EE 3 and EE 8, respectively. Therefore, with respect to an ability to read X-rays, it is reasonable that she is more qualified than both of them.[16]

With respect to the re-readings of the April 15, 2002 X-ray, I note that Dr. Wheeler, Scott, Repsher and Dahhan do not find even simple pneumoconiosis in reading the April 15, 2002 X-ray. EE 4, EE 5 and EE 8. Drs. Wheeler and Scott find that the films are of excellent quality. They find the film is positive, but attribute the masses on X-ray to chronic obstructive pulmonary disease, tuberculosis, and cancer. Contrary to the opinions of Drs. Wheeler, Scott and Deponte, who find that X-ray is of excellent quality, Dr. Scatarige and Dr. Repsher both determined that the film quality is overexposed. Dr. Dahhan also finds that this X-ray is of excellent quality, and although he finds some aspects generally associated with pneumoconiosis, he does not find even simple pneumoconiosis. EE 5.

I note that there have been controversies over X-rays taken in 1988, 1992 and 1996, with readings that purported to show the existence of complicated pneumoconiosis, and that other judges have determined that the Claimant had not proved entitlement to an irrebuttable presumption at that time. I also note that all of the Employer readers except Dr. Dahhan also found X-rays taken June 5, 2000, September 25, 2000 and December 4 and 9, 2000 as negative for even simple pneumoconiosis. I also note that there is controversy surrounding the effect of the May, 2001 X-ray and the CT scans performed in 2001. I note that the employer argues that additionally, the regulations do not provide standards for the interpretation of CT scans similar to the ILO classification system for x-rays described at 20 C.F.R. § 718.102. The Employer argues that although a CT scan may be used for diagnostic purposes, the ILO classification system is not applicable to CT scans and therefore, Dr. Navani's utilization of a CT scan for this purpose is improper. Dr. Navani's report does not support a finding of complicated pneumoconiosis in the

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[14] The Benefits Review Board has indicated that a seven month time period between x-ray studies is sufficient to apply the "later evidence" rule, but that five and one-half months is too short a time period. ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1983); ***Stanley v. Director, OWCP***, 7 B.L.R. 1-386 (1984). However, in ***Aimone v. Morrison Knudson Co.***, 8 B.L.R. 1-32 (1985), the Board held that it was proper for the administrative law judge not to apply the "later evidence" rule where eight months separated the dates of the x-ray studies.

[15] See Brief of Employer, at 9.

[16] In ***Roberts v. Bethlehem Mines Corp***., 8 B.L.R. 1-211, 1-213 n. 5 (1985), the Board held that it "takes official notice that the qualifications of a certified radiologist are at least comparable if not superior to a physician certified as a reader pursuant to 42 C.F.R. § 37.51 . . .."

Claimant. I accept that in this case, under 20CFR §727 203(a)(1), a CT scan is not a "chest roentgenogram (X-ray), biopsy, or autopsy..." required by the regulation. However, a CT scan may be included in (4):

> Other medical evidence, including the documented opinion of a physician exercising reasoned medical judgment, establishes the presence of a totally disabling respiratory or pulmonary impairment.[17]

However, I accept that Dr. Nivani and Dr. Deponte did not proffer a well documented or well reasoned report that could rationalize whether complicated pneumoconiosis exists in this record relating to the CT scans.[18]

I note that there is a wide variance among the expert opinions in this case and that the Claimant and Employer take polar positions with respect to readings the X-rays taken during the period from March, 2000 to March, 2001. I note that the Claimant has the burden to show whether the Claimant had complicated pneumoconiosis during this period. After a review of all of the evidence, to a degree of reasonable probability, the Claimant did not show that complicated pneumoconiosis was present. I note that throughout this period, Dr. Dahhan, although not as qualified as the board certified radiologists, took a position that was consistent; that the Claimant's X-rays showed he had simple, but not complicated pneumoconiosis. Dr. Satarige, who is board certified in radiology took the same position on the March 15, September 25, December 4 and December 9 X-rays.

Dr. Wheeler took this position as to the March 15, 200 X-ray but read the others as not showing pneumoconiosis.

During this same period, the Claimant also had the biopsy and the CT scans performed. Although I give only limited weight to the opinions of Dr. Repsher, Scott, Kim and to Dr. Wheeler for this period as they would deny the Claimant the benefit of the interim presumption, I

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[17] CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. ***Melnick v. Consolidation Coal Co.***, 16 B.L.R. 1-31, 1-33-1-34 (1991).

[18] A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. ***Hoffman v. B&G Construction Co.***, 8 B.L.R. 1-65 (1985); ***Hess v. Clinchfield Coal Co.***, 7 B.L.R. 1-295 (1984); ***Justus v. Director, OWCP***, 6 B.L.R. 1-1127 (1984). Indeed, a treating physician's opinion based only upon a positive x-ray interpretation and claimant's symptomatology was deemed sufficiently documented. ***Adamson v. Director, OWCP***, 7 B.L.R. 1-229 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. ***Fields***, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder-of-fact to decide. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149 (1989)(en banc).

give significant weight to the fact that the Claimant failed to substantiate Dr. Deponte, Navani, Coburn, and Robinette when all of the evidence is weighed for this period.

I agree that the May 13, 2001, X-ray is also questionable because of its clarity, and the Claimant's readings' failure to adhere to the quality standards. The Claimant's readings, standing alone, do not impart sufficient evidence to show that the Claimant has complicated pneumoconiosis. I accept the Employer's argument that the interpretations of the April 26, 2001 CT scan and the follow-up scan of July 9, 2001 do not substantiate the opinions of Drs. Mullens and Navani as to complicated pneumoconiosis, and therefore, absent further proof, the Claimant can not meet his burden as of that time. I note that the report dated April 26, 2001 from Johnston Memorial Hospital (DE 151 at 3) does establish the presence of simple pneumoconiosis and I credit that finding as I consider the report to be reliable, but I also note that there is no signature attached and on it's face there is no opinion rendered concerning whether complicated pneumoconiosis is shown. I accept that Dr. Mullen's opinion is equivocal as to the existence of complicated pneumoconiosis.[19] I note that Dr. Navani's recent qualifications were not submitted.[20]

I also note that the series of X-rays taken starting in March, 2000 and ending in May, 2001 were taken in a sequence where each succeeding X-ray, more recent than the prior one, engendered controversies regarding whether complicated pneumoconiosis was present in the record. I note that the time lapses involved in each succeeding X-ray were relatively short compared to the thirteen (13) month lapse of time between the March 13, 2001 X-ray and the April 15, 2002 X-ray. The Claimant has not presented sufficient proof, based on those X-rays and based on the CT scans, and the biopsy that complicated pneumoconiosis was present. I credit the reports of Dr. Broudy, Teutur, Caffrey and Sherman, to the extent that complicated

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[19] A physician's report, which is silent as to a particular issue, is not probative of that issue. However, the report should not be discredited as a whole on this basis as he or she may provide documented and reasoned opinions relevant to the resolution of other entitlement issues in the claim. For example, in ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 (4th Cir. 2000), the administrative law judge concluded that the miner did not establish pneumoconiosis through chest x-ray evidence under §§ 718.202(a)(1), but he did find pneumoconiosis established via medical opinion evidence at §§ 718.202(a)(4). The Fourth Circuit held that it was proper for the administrative law judge to accord less weight to the opinions of physicians who did not consider pneumoconiosis as a possible cause of the miner's total disability where the administrative law judge found that pneumoconiosis was established on the record.

[20] It is improper to accord greater weight to the interpretation of a physician whose qualifications are unknown, such as when s/he is identified only by initials. ***Stanley v. Director, OWCP***, 7 B.L.R. 1-386 (1984). The party seeking to rely on an x- ray interpretation bears the burden of establishing the qualifications of the reader. ***Rankin v. Keystone Coal Mining Co.***, 8 B.L.R. 1-54 (1985).

pneumoconiosis is not shown by pathology and by blood studies.[21] Therefore, I do not accept Dr. Robinette's opinion that the Claimant had complicated pneumoconiosis as of May 9, 2001. DE 151. However, I accept that the record shows that simple pneumoconiosis was proved by a preponderance of the evidence to April, 15, 2002, and moreover, I must emphasize that achievement of the interim presumption has previously been adjudicated in this record.

The record also shows that the Employer had proved rebuttal based on the following:

> (2) In light of all relevant evidence it is established that the individual is able to do his usual coal mine work or comparable and gainful work (see §410.412(a)(1) of this title); or
>
> (3) The evidence establishes that the total disability or death of the miner did not arise in whole or in part out of coal mine employment

20 CFR §727.203(2) and(3). The Claimant has not submitted proof by any preponderance of the evidence to overcome these holdings and a review of the complete record shows that modification prior to April 15, 2002 is not warranted. Moreover, after a review of the entire record, to April 15, 2002, the Claimant has failed to show that he had complicated pneumoconiosis under 20 CFR §727.203(a)(4).

However, in part because of the thirteen (13) month lapse of time, I accord significant weight to the 2002 study.[22] It is proper to accord greater weight to the most recent X-ray study of record. ***Clark v. Karst-Robbins Coal Co***, *supra* and ***Stanford v. Director***, OWCP, 7 B.L.R. 1-541 (1984). In ***Mullins Coal Co. of Virginia v. Director, OWCP***, 483 U.S. 135 (1987), *reh'g. denied*, 484 U.S. 1047 (1988) the Supreme Court stated that pneumoconiosis is a "serious and progressive pulmonary condition."

I also accept that the latest X-ray is readable and therefore discount Dr.Scatarige's and Repsher's opinions on this point. Drs. Wheeler, Scott and Deponte are board certified radiologists and are "B" readers as is Dr. Scatarige. The standard form permits a scale regarding clarity, and all three marked their forms as "excellent" Dr. Dahhan was also able to read the X-ray. To a reasonable degree of probability, I accept that they are more credible than Dr's. Repsher, who is less qualified as he is not a radiologist. I also note that the majority of readers of this X-ray were

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[21] I must note that I reject the opinions of Drs. Repsher, Naeye, Dr. Spagnolo, as they do not accept that the Miner has the benefit of the interim presumption.

[22] The length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. ***McMath v. Director, OWCP***, 12 B.L.R. 1-6 (1988); ***Pruitt v. Director, OWCP***, 7 B.L.R. 1-544 (1984); ***Gleza v. Ohio Mining Co.***, 2 B.L.R. 1-436 (1979). The Board has indicated that a seven month time period between x-ray studies is sufficient to apply the "later evidence" rule, but that five and one-half months is too short a time period. ***Tokarcik***, supra; ***Stanley v. Director, OWCP***, 7 B.L.R. 1-386 (1984). However, in ***Aimone v. Morrison Knudson Co.***, 8 B.L.R. 1-32 (1985), the Board held that it was proper for the administrative law judge not to apply the "later evidence" rule where eight months separated the dates of the x-ray studies.

able to read it. The Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990), although it is within my discretion to do so, ***Edmiston v. F & R Coal Co.***, 14 B.L.R. 1-65 (1990).[23]

I also must discount the opinions of Dr. Wheeler and Scott, although they are eminently qualified, because their opinions are contrary to stipulations of the parties[24], and are contrary to Judges' Levin's and McElroy's Decisions and Orders. That is because the law of this case and the doctrine of issue preclusion requires that I accept that there is pneumoconiosis and that the interim presumption is invoked. Therefore, Dr. Deponte's opinion can not be impeached by an opinion premised on the basis that there is no pneumoconiosis of record, when it has previously been determined by a Decision and Order.

I note that Dr. Sherman and Dr. Naeye did not have the opportunity to examine the April 15, 2002 X-ray and therefore I attribute no weight to their reports on this issue. Dr. Broudy, although credible in part as to the period prior to April 15, 2002, relied in large part on the readings of Dr. Wheeler and Scott et. al. and did not recognize that their opinions were contrary to the law of this case and the weight of the record. I also note that although Dr. Broudy is a "B" reader, he is not board certified in radiology and is therefore not as qualified as Dr. Deponte with respect to an ability to read an X-ray. I give no weight to the opinion of Dr. Tuteur and Dr. Spagnolo, who rely completely on the opinions of Dr. Wheeler, Scott et.al with respect to the April 15, 2002 X-ray. They also failed to accept that the Claimant is entitled to the interim presumption as the Employer conceded that the Miner has simple pneumoconiosis. I note that they are also not radiologists and are not "B" readers and are also less qualified than Dr. Deponte to read the X-ray.

I give some weight to the opinions of Dr. Caffrey, but note that he is not board certified in radiology and is not a "B" reader, and therefore I attribute more weight to the reading of Dr. Deponte, who holds both qualifications.

I therefore accept Dr. Deponte's reading of the April 15, 2002 X-ray and accept her opinion that complicated pneumoconiosis is present in Mr. Keen.

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[23] If the quality of the film is not noted on the x-ray report, then it is assumed to be of acceptable quality if the study is read. ***Auxier v. Director, OWCP***, 8 B.L.R. 1- 109 (1985); ***Lambert v. Itmann Coal Co.***, 6 B.L.R. 1-256 (1983). However, if the film quality is "poor" or "unreadable," then the study may be given little weight. ***Gober v. Reading Anthracite Co.***, 12 B.L.R. 1-67 (1988).

[24] I am bound by this stipulation. ***Richardson v. Director, OWCP***, 94 F.3d 164 (4th Cir. 1996). In Richardson, the Director stipulated to the existence of coal workers' pneumoconiosis with regard to the living miner's claim. The court held that it was error, therefore, for the administrative law judge to find that the record did not support a finding of the disease in the survivor's claim. The court further stated that the stipulation was binding even though presence of the disease was not "manifest from the medical records." The court then remanded the case to the administrative law judge for a determination of whether coal workers' pneumoconiosis hastened the miner's death.

As the Claimant had established entitlement to the interim presumption under 20 CFR §727.203(a)(1), the Employer is precluded from proof that the Claimant is no longer entitled to the interim presumption, as all of the Employer's proof is predicated on a complete denial that the Claimant has even simple pneumoconiosis.[25] If the existence of pneumoconiosis is conceded, the interim presumption is invoked under § 727.203(a)(1) as a matter of law. ***Simpson v. Director, OWCP***, 6 B.L.R. 1-49 (1983). Therefore, I must discount the opinions of all of the Employer witnesses, who base their opinions on an assumption that simple pneumoconiosis is not displayed on X-ray.[26] Moreover, I reject the conclusions of the several experts who have determined, without explanation, that the Claimant's condition actually has improved over time.

If a miner establishes that he has complicated pneumoconiosis according to 30 U.S.C. § 921(c)(3), the onset date is the month during which complicated pneumoconiosis was first diagnosed. ***Truitt v. North American Coal Corp***., 2 B.L.R. 1-199, 1-203 to 1-204 (1979).[27] In ***Truitt***, the Board held that the miner was entitled to benefits from the first month the evidence established that he suffered from complicated pneumoconiosis (in this case the earliest x-ray study

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[25] The Fourth Circuit applied a similar rule in ***Bethlehem Mines Corp. v. Massey***, 736 F.2d 120(4th Cir. 1984), and held that under ***Grigg v. Director, OWCP***, 28 F.3d 416 (4th Cir. 1994), an ALJ's finding of rebuttal at Section 727.203(b)(3) could not stand because two of the three physicians he relied on premised their opinions of no respiratory impairment on a belief that claimant did not have pneumoconiosis, and the interim presumption was invoked by stipulation at 727.203(a)(1). No physician relied on diagnosed "without equivocation that claimant suffered no respiratory or pulmonary impairment of any kind." As there was no other evidence supportive of rebuttal at subsection (b)(3) and the three opinions relied on by the ALJ did not suffice under ***Massey*** and under ***Grigg***'s erroneous premise holding the denial of benefits was reversed and benefits awarded. ***Curry v. Beatrice Pocahontas Coal Co.***, 67 F.3d 517, 523-524, BLR (4th Cir. 1995)(Luttig, J., dissenting), *rev'g* 18 BLR 1-59 (1994).

[26] I note that it is also interesting that Dr. Wheeler had previously found simple pneumoconiosis, (2, 2), when reviewing X-rays taken in 1986, 1989 and 1996 (DX 99).

[27] Under the amended regulations, § 725.503(d) has been amended to address onset determinations in claims involving modification petitions and it provides as follows:

> (d) If a claim is awarded pursuant to section 22 of the Longshore Act and § 725.310, then the date from which benefits are payable shall be determined as follows:
>
> > (1) Mistake in fact. The provisions of paragraphs (b) or (c) of this section, as applicable, shall govern the determination of the date from which benefits are payable.
> > (2) Change in conditions. Benefits are payable to a miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment provided that no benefits shall be payable for any month prior to the effective date of the most recent denial of the claim by a district director or administrative law judge. Where the evidence does not establish the month of onset, benefits shall be payable to such miner from the month in which the claimant requested modification.

20 C.F.R. § 725.303(d) (Dec. 20, 2000).

interpreted as positive for complicated pneumoconiosis), notwithstanding the fact that the study was interpreted as positive two years after it was taken. Therefore, the Claimant is entitled to benefits as of April 15, 2002, the date when Dr. Deponte first diagnosed complicated pneumoconiosis. CX 1. ***Truitt**, supra*.

Conclusion

Accordingly, although the evidence shows that there had been no mistake of fact or law and no change of condition prior to the taking of an X-ray by Dr. Deponte on April 15, 2002, I find that there has been a change in condition in this case, and that now Mr. Keen has proof of complicated pneumoconiosis. After a review of all of the medical evidence and especially the radiographic evidence in this record, I give significant weight to the reading of Dr. Deponte and accept her opinion that the record shows that the claimant now has complicated pneumoconiosis. I find that all of the other opinions regarding this X-ray must be discounted, primarily because they fail to accept that the Claimant is entitled the interim presumption under 20 CFR § 727.203(a)(1). Dee DX 36, at 3 and 6. Rebuttal evidence under 20 CFR §727.203(b) can not overcome an irrebuttable presumption. Therefore, the Claimant is entitled to the benefit of the irrebuttable presumption contained in 30 U.S.C. § 921(c)(3). He is entitled to an irrebuttable presumption that he is entitled as of the date that he was first diagnosed with complicated pneumoconiosis, April 15, 2002.

ORDER

IT IS ORDERED that request for modification filed by **Arnold I Keen** is **GRANTED.** The Responsible Operator, **Beattrice Pocahontas Company** shall:

1. Pay to the Claimant, all benefits to which he is entitled, under the Black Lung Benefits Act, and augmented benefits to his dependant wife, Ruth Keen, commencing as of April 1, 2002, the month in which the Miner became entitled (33 U.S.C. §§ 906(a));
2. Claimant's attorney is granted thirty (30) days to submit an application for fees conforming to the requirements of 20 C.F.R. §§ 725.365 and §§ 725.366.

SO ORDERED.

A

Daniel F. Solomon
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision if filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung

Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.